Glossary

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Actively at Work — Employees are considered actively at work on an employer's scheduled workday if they are performing in the usual manner all of the regular duties of their work on a full-time basis on that day, whether at their usual place of work or at another place if required to travel. Employees are also considered actively at work on a paid vacation day or on a day that is not one of the employer's scheduled workdays only if they were actively at work on the preceding scheduled workdays.

Allowable Charge — The maximum amount a health plan (such as the State Health Plan, an HMO or Medicare) will pay for a covered service. Network providers and facilities are those who have agreed to accept the allowable charge for covered services under the plan.

Annual Enrollment — A period **each** year during which eligible employees and retirees may change health plans only (SHP Savings to Standard, Standard to Savings, SHP to an HMO, HMO to SHP or HMO to another HMO). No other changes are allowed. Health plan changes are allowed each annual enrollment period with the exception of changing to or from the TRICARE Supplement plan and retirees changing to or from the Medicare Supplemental plan. See also *Open Enrollment*.

Basic Salary — The actual amount for which an employee is compensated by the employer per year, including merit and longevity increases. Basic salary does not include commissions, annuities, bonuses, overtime or incentive pay. For a teacher, basic salary does not include compensation for summer school.

Child — See *Dependent Child.*

COBRA — Consolidated Omnibus Budget Reconciliation Act of 1985. This Act requires that continuation of group insurance coverage be offered to covered persons who lose health or dental coverage due to a qualifying event as defined in the Act. See also *Qualifying Event*.

Coinsurance — Coinsurance is the percentage of covered medical expenses a subscriber must pay in conjunction with the percentage paid by an insurance plan for covered expenses. These amounts are called coinsurance because both the subscriber and the insurance plan share the cost of health care expenses.

Coinsurance Maximum — The coinsurance maximum is the most money a subscriber would pay in eligible coinsurance each year before an insurance plan begins to pay 100 percent of the allowable charge for covered expenses. This does not apply to the Medicare Supplemental plan.

Coordination of Benefits — A system to eliminate duplication of benefits when a person is covered under more than one group plan. Benefits under the two plans are limited to no more than 100 percent of the claim.

Copayment A copayment is a fixed-dollar amount of covered medical expenses a subscriber must pay in addition to what is paid by an insurance plan for covered expenses. These amounts are called copayments because both the subscriber and the insurance plan share the cost of healthcare expenses.

Copayment Maximum The most money in eligible copayments a subscriber would pay each year before an insurance plan begins to pay the entire allowable charge for covered expenses.

Covered Dental Expense An expense that is provided for and deemed medically necessary by the plan up to the maximum amount listed in the *Schedule of Dental Procedures and Allowable Charges* (fee schedule) and is not excluded by any term, condition, limitation or exclusion of the Plan.

Covered Medical Expense A medical expense that is provided for by an insurance plan. A covered expense is a charge that is not excluded by any term, condition, limitation or exclusion of the Plan.

Covered Person A person (employee, retiree, survivor, COBRA participant or dependent) who has met the eligibility requirements and is enrolled in an insurance plan. See also *Enrollee* and *Subscriber*.

Creditable Coverage Prior coverage under a group health plan or insurance coverage or health benefits provided as described or defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Proof of creditable coverage (a form from your previous insurance company listing your dates of coverage) may be used to reduce a pre-existing condition limitation period, provided the prior coverage was continuous (provided any break in coverage did not exceed 62 days).

Deductible The amount a subscriber must pay each year if an annual deductible, or each encounter if a per-occurrence deductible, toward covered expenses before the insurance plan begins paying benefits.

Deferred Effective Date A delayed effective date for insurance coverage, applicable to an employee who is absent from work due to injury or sickness on the date coverage would otherwise have become effective. The effective date is then deferred until the individual returns to work as an active, permanent, full-time employee for one full day.

Dental Course of Treatment All treatment performed in the oral cavity during one or more sessions as the result of the same diagnosis. Treatment includes examination, X-rays, prophylaxis and any complications arising from such treatment. Note: Some surgical procedures may be covered by a subscriber's health plan.

Dental Deductible The amount of covered dental expenses you must pay before the plan will pay Class II and Class III combined benefits.

Dental Schedule of Procedures and Allowable Charges The list of dental procedures covered by the State Dental Plan and the allowable charges for each procedure established by the Plan Administrator for the payment of covered dental services.

Dentist Dentist or physician licensed in the jurisdiction where services are performed and practicing within the scope of his license.

Dependent Child An unmarried child under 19 years of age (or under age 25 if a full-time student) and who is principally dependent upon the subscriber for maintenance and support, provided the child is: (1) the natural or adopted child, stepchild, foster child or child for whom the subscriber has legal custody and who resides in the subscriber's home in a parent-child relationship; or (2) for whom the subscriber provides support and maintenance due to a court order. See also *"Full-time Student"* and *"Incapacitated Child."*

Dependent Spouse A lawful spouse of a subscriber, or former spouse required to be covered by a divorce decree or court order, but not both. If a spouse is also eligible for coverage or benefits as an employee of a participating employer, the spouse may not be covered as a dependent. However, a part-time teacher who is the spouse of a covered employee who is an employee of a participating employer may be covered as either an employee or as a dependent, but not as both.

Employee An employee is a person employed by the state, a school district or a participating local subdivision who must be working at least 30 hours* a week in a position classified by the employer as permanent and full-time, and who receives compensation from a department, agency, board, commission or institution of the state, a school district or a participating local subdivision. This includes clerical and administrative employees of the S.C. General Assembly and judges in the state courts. S.C. General Assembly members and elected members of participating county or municipality councils who participate in the South Carolina Retirement Systems (SCRS) also are considered employees for insurance purposes. If you work for two covered employers (dual employment), please contact your benefits administrator for further information. Permanent, part-time teachers are eligible for state health, dental, Dental Plus, MoneyPlu$ and vision care program benefits.
**Employers who participate in the Employee Insurance Program also have the option of reducing the threshold for insurance eligibility for permanent employees from 30 hours per week to at least 20 hours per week. This is at the option of the employer, and you should contact your benefits administrator for further information.*

EIP The Employee Insurance Program.

Enrollee A person (employee, retiree, survivor, COBRA participant or dependent) who has met the eligibility requirements and is enrolled in an insurance plan. See also *Covered Person* and *Subscriber*.

Enrollment Date (1) The hire date for an employee; (2) the effective date of coverage for an individual who enrolls under a special eligibility situation and for a late entrant; and (3) the retirement date for a retiree.

Exclusion A specific condition or circumstance for which an insurance plan or policy will not provide benefits.

Extended Care Benefits Benefits that provide for medical care in a more cost-effective setting when hospitalization is not required or necessary. Extended care benefits include home health care, skilled nursing facility care, hospice care and alternative treatment plans.

Funded Retiree Funded retirees are those retirees who are eligible for the employer contribution to their retiree insurance premiums

Full-time Student An unmarried child who is 19 years of age but less than 25 years of age who is enrolled in and attending a high school, trade, vocational or technical school or college (not correspondence courses) on a full-time basis as defined by the institution.

Health Maintenance Organization (HMO) A managed care plan that has contractual arrangements with healthcare providers (doctors, hospitals, etc.) who together form a provider network. HMO subscribers are required to see only providers within this network. If a subscriber receives care outside of this network, the HMO will not pay benefits for these services unless the care was pre-authorized or deemed an emergency. Subscribers choose a primary care physician (PCP) who coordinates all aspects of the subscriber's healthcare. To receive benefits, subscribers must receive a referral from their PCP before they can see a specialist.

Home Healthcare Part-time nursing care; health aide service; or physical, occupational or speech therapy provided by an approved home health care agency and given in the subscriber's home. These services do not include custodial care or care given by a person who ordinarily lives in the home or a member of the subscriber's family or the spouse's family.

Hospital A legally designated and operated institution caring for the sick, such as a general hospital; children's hospital; eye, ear, nose and throat hospital; maternity hospital or an ambulatory surgical center. "Hospital" also includes a legally constituted and operational psychiatric facility for the treatment of mental or nervous conditions or substance abuse. Hospitals must provide inpatient care given by, or supervised by, a staff of licensed physicians and must provide continuous 24-hour services by licensed registered nurses who are physically present and on duty. Nursing homes, rest homes, homes for the aged and convalescent homes are typically not considered hospitals under insurance plans, whether or not they are affiliated with a hospital.

Incapacitated Child An unmarried child who is incapable of self-sustaining employment because of mental illness or physical handicap and is principally dependent on the subscriber for maintenance and support. Incapacitation must have begun before age 19 or while an eligible covered dependent, full-time student. If eligible but not previously covered, the child may not be added until the next open enrollment period (or within 31 days of a special eligibility situation), and coverage is subject to pre-existing condition limitations.

Incurred Expense An expense is considered incurred on the date services were rendered or supplies were received.

Identification Number For most plans, typically the covered person's Social Security number. Identification cards are issued by the insurance plan. Note for retirees: Under the State Health Plan Savings, Standard or Medicare Supplemental plan, the retiree's Social Security number is used for all covered family members. Use the number listed on the Medicare card for Medicare claims and information. Note for survivors: For surviving spouses and surviving spouses with covered children, the surviving spouse's Social Security number is used for all covered family members. For surviving children only, the youngest child's Social Security number is used.

Injury An accidental bodily injury that requires treatment by a physician. Any loss that results from the injury must be independent of sickness or other causes.

Late Entrant A full-time employee or eligible retiree, and any eligible dependent of that employee or retiree, who is not enrolled within 31 days of that person's first date of eligibility and who subsequently enrolls during an open enrollment period. A late entrant is subject to the pre-existing condition exclusion for 18 months after coverage begins.

Local Subdivision Any participating employer covered by local jurisdiction rather than state. Examples of local subdivisions include: counties, councils on aging, commissions on alcohol and other drug abuse, special purpose districts, community action agencies, disabilities and special needs boards, municipalities, recreation districts, hospital districts and councils of government. Since 1985, the General Assembly has passed legislation extending voluntary participation in the state insurance benefits program to certain local subdivisions. To be eligible to participate in the state insurance benefits program, a public employer in South Carolina must fall within one of the categories established by statute (Section 1-11-720 of the 1976 S.C. Code of Laws, as amended).

Medi-Call Medi-Call is the patient utilization review program for State Health Plan subscribers. Medi-Call ensures subscribers receive appropriate medical care in the most beneficial, cost-effective manner. Note: Retirees and dependents eligible for Medicare must call Medi-Call for home health care, hospice, durable medical equipment, Veterans Administration hospital services and when the number of hospital days allowed by Medicare is exceeded.

Medically Necessary Services or supplies ordered by a physician or behavioral healthcare provider to identify or treat an illness or injury. Services and supplies must be given in accordance with proper medical practice prevailing in the medical specialty or field at the time the patient receives the service and in the least costly setting required for the patient's condition. The service must be consistent with the patient's illness, injury or condition and be required for reasons other than the patient's convenience. The fact that a physician prescribes a service or supply does not necessarily mean it is medically necessary.

Medicare Supplemental Plan — A health plan offered to retirees and their dependents who are eligible for Medicare. As a "supplemental" plan, it generally pays the deductibles and coinsurance amounts for Medicare approved services that Medicare does not.

Mental Health and Substance Abuse Provider — A physician, psychiatrist, health professional or any other entity or institutional health care provider under agreement to participate in a behavioral health provider network administered by the APS Healthcare, Inc.

Non-funded Retirees — Non-funded retirees are those retirees who do not qualify for funded benefits and who must pay the full premium cost (includes retiree share plus employer contribution) for their insurance.

Non-Preferred Brand Drugs — Medications that do not appear on the preferred drug list and that carry a higher copayment. All non-preferred drugs have an effective alternate option either as a generic or preferred brand drug.

Notice of Election Form — The Notice of Election (NOE) form is the application form used to enroll in benefits; add or delete dependents; or change coverage level, beneficiary, name or address.

Open Enrollment — A period during which eligible employees, retirees, survivors and COBRA subscribers may enroll in or drop their own coverage and add or drop eligible dependents to/from a health plan without regard to any special eligibility situations. Retirees may also change to and from the Medicare Supplemental program during an open enrollment period. An open enrollment period is held in odd-numbered years during October. Enrollment changes become effective the following January 1.

Out-Of-Network Differential — If you choose to go to a healthcare provider that does not participate in a State Health Plan network, you will be responsible for a higher coinsurance percentage of your covered medical expenses and you may be balance-billed the difference between the allowed and actual charge. This out-of-network differential applies to all State Health Plan networks except the Mental Health and Substance Abuse and Pharmacy networks where no out-of-network benefits are provided.

Out-Of-Pocket Maximum — The most money a covered person will be required to pay a year in deductibles, copayments and coinsurance. The amount is set by each insurance plan.

Part-Time Teachers — Teachers, who are in a permanent position and work at least 15 hours but no more than 29 hours per week at a South Carolina public school, the South Carolina Department of Juvenile Justice or the South Carolina Department of Corrections are eligible for state health, dental MoneyPlu$ and vision care program benefits. They must also be in a contract position and receive an Education Improvement Act (EIA) salary supplement. Premiums are determined by the number of hours an eligible part-time teacher works per week.

"Pay-the-Difference" Policy	If a generic drug is available and a subscriber chooses to purchase or his doctor prescribes the brand name medication instead, the benefit will be limited to the amount payable for the generic medication. The subscriber will be responsible for the difference in benefit between the brand-name drug and the generic drug, plus the generic copayment amount. The difference does not apply to annual copayment maximum.
Per-Occurrence Deductible	The amount a covered person must pay each time he receives an emergency room, inpatient or outpatient hospital service before the health plan begins to pay benefits.
Per-Visit Deductible	The amount a covered person must pay each time he receives services in a professional provider's office before the health plan begins to pay benefits.
Physician	A licensed medical doctor, dentist, oral surgeon, podiatrist, osteopath, chiropractor, psychiatrist or licensed counseling or clinical psychologist.
Plan	The State Health Plan or the State Dental Plan.
Plan Year	January 1 through December 31.
Point of Service (POS)	A managed care plan that allows subscribers to choose to use providers or specialists within the plan's network as referred by their primary care physician, or subscribers can self-refer to a provider outside the network. Subscribers may use out-of-network services; however, benefits are paid at a reduced level.
Pre-Existing Condition	Any medical condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received by a licensed healthcare provider or practitioner in the six months preceding the covered person's enrollment date. Benefits for a pre-existing condition are payable only for treatment provided at least 12 months (18 months for a late entrant) after enrollment. Pregnancy does not constitute a pre-existing condition. See also *Creditable Coverage.*
Preferred Brand Drugs	Medications that have been determined safe, effective and available at a lower cost by Medco's Pharmacy and Therapeutics Committee. A list of preferred drugs is available at www.medco.com.
Preferred Provider Organization	A PPO is a type of health or dental plan that is similar to a fee-for-service plan. A PPO has arrangements with doctors, hospitals and other providers who have agreed to accept the plan's allowable charges for covered medical services as payment in full and will not balance bill you. Participating providers also file claims for you.
Premium	The amount a covered person pays in exchange for insurance coverage.

Prescription Drugs Any drugs or medicine required to bear the following wording, "Caution: Federal law prohibits dispensing without prescription." Insulin or drugs licensed or accepted for a specific diagnosis as listed in the U.S. Pharmacopoedia Publication, *Drug Information for Health Care Professionals*, are also considered prescription drugs. Drugs in FDA phase I, II or III testing are not covered.

Primary Care Physician/Doctor Usually the first contact for healthcare, this is often a family physician, internist, pediatrician, or in some cases, a gynecologist. A primary care physician monitors the patient's health and diagnoses and treats minor health problems and refers the patient to specialists if another level of care is necessary.

Private Duty Nursing Services Private services of a registered nurse or licensed practical nurse. Services must be certified in writing by a physician as medically necessary.

Provider Any person (i.e., doctor, nurse, dentist) or facility (i.e., hospital or clinic) that provides medical care.

Qualifying Event An event that allows insurance coverage or an extension of insurance coverage for an employee, spouse or dependent. Such events may be marriage, birth/adoption/placement, loss of group health plan coverage, divorce/legal separation, death of the covered employee, loss of dependent's eligibility for coverage, etc.

Self-Insured Plan A self-insured insurance plan is one in which the employer or group of employers assumes direct financial responsibility for the costs of enrollees health claims. Employers sponsoring self-insured plans typically contract with an insurance carrier or third party administrator to provide administrative services for the self-insured plan.

SHP See *State Health Plan.*

Sickness A disease, disorder or condition that requires treatment by a physician.

Significant Break in Coverage A period of 63 or more consecutive days during which an individual does not have any creditable insurance coverage. Neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. See also *Creditable Coverage.*

Skilled Care Services provided according to a physician's order, given by or under the direction of a qualified technical or professional healthcare provider. Healthcare providers include registered nurses, licensed practical nurses, physical therapists, speech pathologists and audiologists.

Special Eligibility Situation A qualifying event that allows eligible employees, retirees, survivors or COBRA subscribers to enroll themselves and/or their eligible dependents in an insurance plan. Examples include: marriage, birth, adoption or placement. Involuntary loss of other coverage applies only to those who lost coverage. Enrollment changes must be requested within 31 days of the qualifying event. Note: A salary increase does not constitute a special eligibility situation. See also *Qualifying Event*.

Spouse	See *Dependent Spouse*.
State-Covered Employer	A state agency, public school district, county, municipality or other group participating in the Plan.
State Health Plan (SHP)	The term used generally to identify the Savings, Standard, and Medicare Supplemental plans.
Subscriber	All active and retired employees, survivors and COBRA subscribers of state agencies, public school districts, participating counties and other eligible employers, and their dependents who are enrolled in a benefits plan. See also *Covered Person* and *Enrollee*.
TERI	Teacher and Employee Retention Incentive program of the South Carolina Retirement Systems.
Transfer/ Transferring Employee	An active employee who changes employment from one state group employer to another with no more than a 15-calendar-day break in employment or in insurance coverage. An academic employee who completes a school term and moves to another academic setting at the beginning of the next school term is also considered a transferring employee. A transferring employee is not considered a new hire for insurance program purposes.
You	Any person who is insured under the policy. You and/or your covered dependents.